# Caring for emergency service personnel: Does what we do work?

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Paper presented at the

Australia & New Zealand Disaster & Emergency Management Conference, Surfers Paradise (QLD), 5th-7th May 2014

# Caring for emergency service personnel: Does what we do work?

**ABSTRACT:** Most emergency service organisations have some form of staff support program that share general aims of promoting and maintaining the mental health of their workforce. Yet few of these services have been subject to evaluation and fewer still have commissioned external professional researchers to scrutinise their programs. The Queensland Ambulance (QAS) Service provides a comprehensive and multifaceted program that is both proactive and reactive in design and with the support of the Commissioner, was the subject of a rigorous evaluation throughout 2013. In this paper the program services are briefly outlined and the considered approach to the evaluation is presented within the context of existing scientific literature. Using focus groups, information regarding the uptake of the program's various 'arms', and survey data, results suggest the program is widely used and that staff are very satisfied with the services provided. Further, analysis of established psychometric measures demonstrated organisational and interpersonal factors that are important in the promotion of mental health and in warding off the deleterious impacts that frontline emergency service staff can endure. Data presented in this paper indicate how best to ensure a professional quality of life for ambulance personnel, how to promote resilience to the sometimes extremely challenging aspects of the work role, and ways in which difficulties such as depression may be minimised.

**Keywords:** staff support services, employee assistance programs, well-being, evaluation

## Introduction

Given the complex and often chaotic nature of their work, emergency service personnel such as paramedics and emergency medical dispatchers, are at a heightened risk of experiencing extremely stressful and sometimes traumatic events. With a goal of mitigating the risk of such experiences on well-being, emergency service organisations offer employee assistance programs (EAPs) that are developed and largely delivered 'in house' or are outsourced to human resource and psychological agencies. In addition to the ethical obligation of providing an EAP for staff, providing professional support services is an organisational obligation in order to adhere to an increasingly scrutinised provision regarding an employer's *duty of care*. Yet very few organisations have opened themselves up to a rigorous and transparent

evaluation of the staff support services they provide. In this paper a summary of best practice in evaluating EAPs is presented and then the method undertaken in this evaluation of the Queensland Ambulance Service's (QAS) EAP is outlined. Due to the constraints of this paper only major results are described which is followed by a general discussion.

Literature reflects that very little empirical research has been conducted to determine the long term value of EAPs to both the employer and the employee (Alker & Cooper, 2007). Providers tend to publish summary data and statistics of their effectiveness through articles and media releases in organisational literature, but these publications are essentially internal evaluations lacking clear transparency of empirical evidence. In an attempt to more clearly identify current empirical evidence of EAP evaluations, Csiernick (2011) conducted two extensive academic literature reviews which encompassed a combined period of 20 years (1989-2009). Csiernick's reviews of the EAP evaluation literature illustrated that a variety of methods are used by organisations, often tailored to meet differing organisational needs and structures. However, many of the approaches do not follow comprehensive steps of evaluation and their methodologies do not contribute significant growth in understanding effective evaluation processes to the academic literature.

Courtois and colleagues (2005) proposed that to develop an EAP evaluation for an organisation, the following factors need to be identified first; aspects of the EAP being evaluated, the purpose of the proposed measures, the type of measures, and how they will be used. A comprehensive plan needs to be devised prior to implementation to ensure that the evaluation is both empirical and meets the needs of the organisation. Csiernick, Chaulk and McQauid's (2012) study represents one of the most current and comprehensive EAP process evaluations where a focus group and one-on-one interviews were conducted to enable pertinent issues to be forthcoming before development and administration of a survey. Csiernick et al., conducted in-depth qualitative group and individual interviews with key informants including human resource managers, senior managers, senior labour leaders, internal and external counsellors and volunteer employee EAP users. Participants were questioned on a variety of areas including; counselling services, workplace education and wellness, program promotion, operation and governance. This approach enabled these stakeholders to generate their own knowledge and observations of the program and to identify strengths and weaknesses with the EAP. Input from a wide range of varying employees' positions can inform a committee overseeing the project and provide more direction than from a merely speculative stance (Csiernick, 1995). However whilst focus

groups are informative, this is distinctly different from a comprehensive employee needs assessment where greater numbers and a wider range of employees is needed to be fully representative (Csiernick, 1995).

Process evaluations have been found to use multiple sources of data for measurement including focus groups, interviews, client satisfaction of services accessed, surveys conducted on a sample of the workforce, program utilisation, and work performance in addition to absenteeism data (Csiernick, 2011). Implementing process evaluations can be a more complex undertaking, however they can also provide vital information on how a current EAP is being translated into outcomes, defining what is and is not working well, thereby enabling recommendations for adjustments (Csiernick et al., 2012). Outcome measurements can also be used in process evaluations with self-reflective data collection in the form of satisfaction ratings through surveys which can provide vital information on potential problems or changes needed for EAPs (Shumway, Kimball, Korinek & Keeling, 2006). Simple measures can be used or complex instruments that combine satisfaction with additional outcome evaluations (Shumway et al., 2006).

Survey data about the satisfaction levels of current EAPs can provide important information on the success of the services. Also, the use of feedback from clinical counselling services can be used to identify stressful areas within the organisation when multiple areas of information are placed together (Arthur, 2004). Essentially, to provide a rigorous and detailed EAP evaluation involves a complex series of research collection and data analyses. The outcomes of extensive, well planned and developed methodology can bring forward important and useful data for organisations who take their EAPs seriously as a genuine and essential service they provide to their employees.

The QAS has a comprehensive EAP called Priority One. A full description of the program was provided by Scully (2011) and the EAP was first evaluated in 2003 (Shakespeare-Finch & Scully, 2004). The services include trained peer support officers, professional counsellors (e. g., psychologists; social workers) who are external to the organisation, professional internal counsellors (all of whom have also been paramedics of various ranks), a 24 hour telephone service, a chaplaincy, gay and lesbian support group, indigenous support group, and many psychoeducation programs that begin in basic training.

To provide a rigorous and detailed evaluation of the Priority One program the current methodology was formulated through empirical investigation. The outcomes will include

detailed insights into the efficiency of the EAP and value of the current services through determining usage of EAPs, employee satisfaction of EAPs, relationships between the EAP and other measures of well-being, and identifying any new needs of employees with respect to the EAP services. An additional benefit of an EAP evaluation is that is indicates to employees that the organisation's culture is one that cares about the services they provide to their staff. The use of combined methods of data collection and analysis holds the potential to provide well-informed recommendations through empirical research.

## Method

### *Review Committee*

As proposed by Csiernick (1995), a committee can add value and rigor to process evaluations especially when conducted by a third party to the organisation and when expert advice is also sought from people in various roles throughout the organisation. Consistent with this premise, an academic with extensive research experience and specific knowledge of trauma research in emergency service contexts was invited to Chair a committee. The committee was further comprised of three external professional psychologists, an Assistant Commissioner, a Paramedic, an Officer-in Charge, an Operations Centre Manager, and a Manager of Clinical Education. Following a review of current literature regarding best practice in process evaluation of an EAP, measures were discussed and agreed upon, as was a methodology. The committee agreed that a series of stratified focus groups would be an important step in ensuring all questions aiding the evaluation were asked when subsequently sending a survey to all employees.

### *Focus Group Participants and Procedure*

Five focus groups were conducted in March, 2013. Two groups were facilitated by the committee Chair and three were conducted by a psychologist who provides services to the QAS but is in private practice. Both facilitators were experienced researchers. The groups consisted of open discussions for one to two hours focussing on the Priority One EAP. There were 40 participants in total. The first group comprised five senior executives and was held in Brisbane. The second group was held in Townsville and was comprised of six Emergency Medical Dispatchers. The third was a mixed group with one student paramedic, four Advanced Care Paramedics and three Managers and was also held in Townsville. The fourth

group were from the rural areas of North Queensland ($n$ = 10) and the fifth group were 11 Peer Support Officers from various regions throughout the state.

*Focus Group Qualitative Data*

Whilst it is beyond the scope of this paper to provide details of all focus group data, in this section some major themes are outlined in order to provide a context for additional information added to the survey instrument beyond standard demographic questions, satisfaction ratings and established psychological measures. These themes were:

- A need to ensure Priority One resources are meeting the current needs of employees (e. g., identify new issues, assess demand and supply).
- To ensure accessibility of Priority One for all QAS employees (including students, rural etc.) through adequate information and advertising.
- To provide managers/hierarchy with clear insight into benefits of the EAP.
- To assess the extent of desire for knowledge, resources and forums that enable employees to improve their own mental health and well-being and to generate more cohesive work places.
- To review the importance and perceptions of confidentiality with accessing Priority One assistance.
- To assess if improvements to Priority One are needed (e.g., other services, apps, social media).

These themes (and others) were transformed into questions for example, "Are there other services you think Priority One can offer that would be beneficial to your well-being"? Other questions added to the survey related to if an employee had accessed a particular service, how satisfied they were with that service, and who they had sought assistance from, if anyone, in times of need.

*Survey Participants*

The survey participants were 1042 current employees of the Queensland Ambulance Service which is a response rate of approximately 30% of all personnel. 64.3% of the sample was male and 35.7% was female. Participants' ages ranged from 20 to 69 years with a mean age of 40.87 years ($SD$ = 10.45). Length of service ranged from six months to 56 years ($M$ = 11.18, $SD$ = 9.39). Most participants were married (76%), 15% were single, 4% were divorced, 3% separated, 0.3% widowed and 1.7% did not indicate a relationship status. Only 8.5% of respondents were trained Peer Support Officers (PSOs). Nearly 59% of participants had accessed a Priority One Service. People occupying all QAS job roles were represented

with the largest group comprising Advanced Care Paramedics (56%) and the next largest in number being Emergency Medical Dispatchers (10.6%).

*Survey Materials*

Based on the focus group data and a review of current literature, a questionnaire was compiled. A number of demographic questions were asked for example, age, gender, relationship status, work role and region, if the participant had experienced trauma and if so what the nature, frequency, and intensity of the experience was. The survey also contained five scales measuring 1) satisfaction with the Priority One EAP, 2) a resilience measure, 3) a measure of organisational connectedness, 4) a measure of distress (depression and anxiety) and 5) the Professional Quality of Life scales. A description of these scales follows.

*Priority One Satisfaction Scale.* An evaluation of the QAS EAP was undertaken in 2003 (see Shakespeare-Finch & Scully, 2004). At that time a series of items were developed to assess general satisfaction levels with the Priority One program and satisfaction with 4 of the EAPs most frequently used resources: External counsellors, Peer Support Officers (PSOs), telephone counselling, and debriefing/defusing. In order to assess satisfaction levels with the EAP, five items representing each of these domains of care (total of 25 items) were included in the survey battery. Participants were asked to respond on a 5-point likert scale regarding the extent to which they agreed or disagreed with each item.

*The Professional Quality of Life Scale (ProQOL;* version 5, Stamm, 2010). The ProQOL is used as a measure of both negative and positive effects of helping others who experience trauma. The scale consists of 30 items measuring three constructs of compassion satisfaction, burnout, and secondary traumatic stress. The compassion satisfaction subscale measures the extent people experience pleasure through their work. Compassion fatigue is measured with two subscales: burnout, which measures feelings of hopelessness and difficulties in a person's ability to do their job, and Secondary Traumatic Stress, which assesses the impact of work-related indirect exposure to traumatic events (Stamm, 2010). Each subscale comprises 10-items and respondents are asked to report the frequency each item was experienced in the previous 30 days on a 5-point rating scale ranging from 1 (*never*) to 5 (*very often*).

*Psychological Sense of Organisational Membership (PSOM).* Organisational connectedness was measured using the PSOM (Cockshaw & Shochet, 2007), a scale adapted

from Goodenow's (1993) Psychological Sense of School Membership scale. The measure comprises 18 items scored from 1 (*not at all true*) to 5 (*completely true*) that assess the extent to which respondents feel accepted, valued and respected in the workplace by peers, supervisors and the organisation in general. An example question is *'I feel like a real part of this organisation'* (Cockshaw, Shochet, & Obst, 2012). Higher scores on the PSOM indicate that the respondent feels a sense of belonging to their workplace.

*The Brief Resilience Scale* measures a person's perceptions of their capacity to recover from stress inducing situations (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008). This scale consists of six items (three of which are reversed) and respondents are asked to indicate the extent to which they agree with statements posed with 1 representing *strongly disagree* and 5 representing *strongly agree.* An example item is "*I tend to bounce back quickly after hard times".* In a detailed development paper Smith and colleagues demonstrate strong convergent and discriminant validity as well as the reliability of their measure. The presence of resilience was also included in the QAS survey as resilience is most often operationalised as an absence of pathology; a premise that is now widely regarded as erroneous.

*The Kessler 10 (K10)* is a measure of distress in the form of symptoms of anxiety and depression. Scoring on this scale can vary but in Australia, most researchers (including the Australian Bureau of Statistics) ask respondents to rate their level of agreement with items from 1 to 5 with 1 indicating the question is true *none of the time* and 5 representing the question is true *all of the time*. An example of a K10 question is *"About how often did you feel that everything was an effort"* (Furukawa, Kessler, Slade, & Andrews, 2003). Given the availability of Australian normative data, the latter format was used in this survey. The K10 has been widely used and is regarded as a reliable and valid measure of distress.

*Procedure*

Approval to conduct this study was obtained from the Queensland University of Technology Human Research Ethics Committee (Approval Number #1300000159) and the Commissioner of the QAS. All QAS staff were invited to participate in the survey component of the evaluation of Priority One. For convenience and to maximise participation, surveys were made accessible to staff in a hardcopy and in an electronic format. Paper surveys were posted by the QAS to employees' addresses and returned directly to the independent researchers, while access to the online survey was promoted via staff email and the QAS

intranet site. The survey packet included information on the purpose of the research, expected risks and benefits of participation, and confidentiality. The survey included questions on demographic information; access to Priority One; the participants' experience of trauma; and five recognised scales relating to distress, well-being, organisational connectedness and professional quality of life as described above in the materials section of this method. Approximately half the surveys were completed online (545). Participation was voluntary and consent was implied through the submission of either the online or hardcopy survey.

## Results

*Survey Results*

The first series of analyses were focussed on the satisfaction participants felt with the services that Priority One provides. Given the multiple comparisons made, a more stringent alpha level was applied of $p<.01$. Those who had accessed the services had significantly higher levels of satisfaction than those who had not accessed the services with respect to the EAP services in general $t(884) = 4.63$, $p < .001$. Debriefing was perceived to be supportive debriefing or defusing rather than formal psychological debriefings that are referred to in the extant literature. Those who had used this form of support trended toward being more satisfied with it than those who had not $t(870) = 3.25$, $p = .019$. Staff who had sought assistance from PSO's were more satisfied than those who had not $t(862) = 3.96$, $p < .001$, and the same was found for external counselling services $t(855) = 11.62$, $p < .001$. No difference in satisfaction levels was found between those who have used telephone counselling and those who have not $t(797) = .977$, $p = .329$.

PSOs and external counsellors were the most heavily endorsed groups with respect to being satisfied with services provided and finding them useful. On a scale of 1-5 with 1 representing the service was "not at all useful" and 5 representing the services were useful "to a great degree", mean levels of satisfaction with counsellors were approximately 4/5 and satisfaction with peer supporters were rated as 3.6/5 demonstrating that overall the participants positively endorsed these services. The age of a participant made no discernible difference to satisfaction levels with Priority One services or to most scores on the well-being scales used: the Psychological Sense of Organisational Membership (PSOM), the Burnout and Compassion Satisfaction scales included in the Professional Quality of Life Scales (ProQOL-V), the K10 as a measure of distress or the brief resilience measure. There was a small but significant correlation between age and the Secondary Traumatic Stress scale ($r = .13$, $p < .01$). Likewise, the length of service of a participant did not differentiate satisfaction

with Priority 1 levels however there was a small but significant correlation between length of service and symptoms of secondary traumatic stress with higher levels of STS in those who had been in the service longer ($r = .21$, $p < .01$). Other correlations were below .1 and therefore considered negligible; only being statistically significant due to the large sample size.

Males and females had significantly different scores on some of the measures used. Females were significantly less likely to experience Burnout $t(945) = 3.27$, $p < .001$ or Secondary Traumatic Stress than their male counterparts $t(945) = 2.87$, $p < .01$ yet there were no sex differences in levels of Compassion Satisfaction $t(945) = -.34$, $p = .71$. There were no differences between males and females on measures of distress $t(880) = .78$, $p = .43$ or resilience $t(970) = -1.12$, $p = .26$. However the sexes demonstrated significantly different scores for all of the Priority One services as can be seen in Table 1 below. Females were significantly more satisfied with all Priority One services when compared to male participants with the exception of external counsellors.

Table 1

Means, Standard Deviations, t scores (with degrees of Freedom), and Significance Levels for Males and Females on Priority 1 Satisfaction Levels

| Service accessed | | Mean | Standard Deviation | T score (*df*) | Significance level |
|---|---|---|---|---|---|
| P1 in general | Males | 15.93 | 3.63 | -2.58 (893) | <.01 |
| | Females | 16.57 | 3.32 | | |
| Phone | Males | 14.09 | 4.36 | -3.64 (803) | <.001 |
| | Females | 15.23 | 4.24 | | |
| Supportive debriefs | Males | 16.32 | 5.11 | -3.77 (876) | <.001 |
| | Females | 17.65 | 4.74 | | |
| Peer Support | Males | 17.59 | 5.12 | -3.10 (869) | <.01 |
| | Females | 18.68 | 4.55 | | |
| Counsellors | Males | 19.26 | 4.99 | -2.14 (861) | <.05 |
| | Females | 19.99 | 4.44 | | |

Table 2 provides correlation coefficients for each of the five Priority One satisfaction measures and the indicators of psychological well-being. As can be seen, the strongest relationships overall are with Compassion satisfaction which was significantly related to levels of satisfaction with all aspects of the Priority One services. The next strongest relationship was with levels of connectedness with the QAS which represents the extent to which participants feel they are valued, respected, and belong within the organisation and levels of satisfaction with the overall Priority One program, debriefing, and peer support officers. Burnout was significantly and negatively related to all aspects of services provided. In short this means that satisfaction with the Priority One services was significantly related to the presence of well-being as measured by compassion satisfaction, to feeling connected to the QAS and that those people satisfied with the services were less likely to experience burnout.

Table 2

Correlations Between Satisfaction Levels With Each Priority One Service and Measures of Well-being.

| | P1 overall | Telephone counselling | Supportive Debriefing | Peer Support Officers | External Counsellors |
|---|---|---|---|---|---|
| Distress (K10) | -.07* | -.06 | -.14** | -.11** | .01 |
| Resilience | .01 | .01 | .05 | .05 | -.12** |
| Connectedness | .26** | .18** | .32** | .29** | .17** |
| Secondary Traumatic Stress | -.01 | -.01 | -.05 | -.02 | .07 |
| Burnout | -.21** | -.16** | -.27** | -.27** | -.12** |
| Compassion Satisfaction | .29** | .20** | .34** | .34** | .22** |

Note. ** = significant at $p<.001$; * = significant at $p<.01$

Further correlations were conducted to ascertain the strength and direction of relationships between the well-being measures. Participants who felt connected (i. e., have a sense of belonging with the QAS) were significantly more likely to experience compassion satisfaction ($r = .37$) and resilience ($r = .22$) and less likely to experience burnout ($r = -.37$), secondary traumatic stress ($r = -.23$) or distress ($r = -.31$). Lower levels of distress (symptoms of anxiety and depression) were significantly related to higher levels of resilience ($r = -.55$),

connectedness ($r$ = -.37) and compassion satisfaction ($r$ = -.38) and those with higher levels of distress were more likely to experience secondary traumatic stress ($r$ = .61) and burnout ($r$ = .65).

There were no differences in the well-being variables as a function of work role with the exception of students who reported significantly higher levels of compassion satisfaction $F(3,852) = 4.48$, $p<.01$ and lower levels of burnout $F(3,852) = 5.07$, $p<.01$ than all other groups. This is to be expected given the lack of experience in the paramedical role students have had and their subsequent lower levels of exposure to work-related challenges. Perhaps students are still in a honeymoon phase of their careers where they are still cognisant of the reason they have chosen this career and are actively seeking to remind themselves of the positive aspect of providing emergency medical care to others.

The participants were then separated into 1) on-road staff only and 2) those who had experienced trauma. In the first group (on-road staff) the majority of participants had accessed Priority One ($n$ = 345, 57%) and had also experienced a traumatic event ($n$ = 465, 77%). Overall respondents were satisfied with Priority One, with the negative skew in the data indicating that most respondents agreed with the survey statements that Priority One was useful. Table 3 provides the descriptive statistics for on-road staff (Paramedics, Advanced Care Paramedics, and Intensive Care Paramedics) with respect to levels of compassion satisfaction, burnout, secondary traumatic stress, connectivity to the QAS, and general levels of satisfaction with Priority One.

Table 3

*Descriptive Statistics and Reliabilities of ProQOL-V subscales, PSOM and EAP Satisfaction*

| Scale | $n$ | $M$ ($SD$) | 95% CI | $\alpha$ | Range | Skew |
|---|---|---|---|---|---|---|
| ProQOL-CS | 602 | 38.63 (6.39) | [38.11, 39.20] | .91 | 10–50 | -0.95 |
| ProQOL-BO | 602 | 22.45 (5.89) | [21.95, 22.95] | .79 | 10–48 | 0.59 |
| ProQOL-STS | 602 | 20.16 (6.29) | [19.64, 20.71] | .85 | 10–49 | 0.92 |
| PSOM | 596 | 3.46 (0.73) | [3.40, 3.52] | .92 | 1.17–5 | -0.37 |
| EAP Satisfaction | 568 | 3.58 (0.99) | [3.49, 3.66] | .88 | 1–5 | -0.73 |

*Note*. CI = confidence interval; ProQOL = Professional Quality of Life scale; CS = Compassion Satisfaction; BO = Burnout; STS = Secondary Traumatic Stress; PSOM = Psychological Sense of Organisational Membership; EAP = Employee Assistance Program.

The paramedics had average levels of compassion satisfaction, and low levels of burnout and Secondary Traumatic Stress as indicated by the mean scores on these subscales. The variability in the ProQOL-V data was also moderate and similar across the subscales, suggesting that there was a good spread of scores across each of the subscales. Visual inspection of the histograms for each ProQOL-V subscale showed that compassion satisfaction scores were slightly negatively skewed, indicating that in general the paramedics obtained pleasure from their helping work. The histograms of the burnout and Secondary Traumatic Stress measures were slightly positively skewed, indicating that fewer respondents experienced extremely negative reactions to their work.

To explore the prevalence of compassion satisfaction, burnout and STS in the sample, participants were placed into categories of low, average and high for each construct, according to criteria outline in the ProQOL-V manual (Stamm, 2010). The number and percent of paramedics in each category is displayed in Table 4. Overall a greater number of paramedics demonstrated low risk of burnout and STS, than the reported norms (25%; Stamm, 2010). Only two participants indicated experiencing psychological problems as a result of their work, as indicated by high burnout and STS scores. The majority of respondents had average levels of compassion satisfaction, and more paramedics (35.5%) reported high levels of pleasure in their job, compared to the benchmark of 25% (Stamm, 2010).

Table 4

*Number and Percentage of Paramedics with Low, Average and High Levels of Compassion Satisfaction, Burnout and Secondary Traumatic Stress*

| Variable | Low (0–22) | Average (23–41) | High (42–50) |
|---|---|---|---|
| | *n* (%) | *n* (%) | *n* (%) |
| Compassion satisfaction | 14 (2.3%) | 374 (62.1%) | 214 (35.5%) |
| Burnout | 302 (53.2%) | 280 (46.5%) | 2 (0.3%) |
| STS | 421 (69.9%) | 179 (29.7%) | 2 (0.3%) |

*Note*. STS = Secondary Traumatic Stress. $N = 602$

The second group of participants subjected to analysis regarding their resilience and distress levels had all experienced trauma. This represented 81.8% of the total sample. For more than half of participants, this event had been perceived as either highly severe (28.4%)

or extremely severe (28.1%). Most employees also indicated that they had experienced more than one traumatic event (90.4%). Over half of ambulance personnel in this group had accessed services provided by Priority One (63.6%). Overall QAS employees had low distress levels and moderately high levels of resilience, workplace belongingness and satisfaction with the services Priority One provides. Consistent with the earlier analysis of on-road staff, the distress scale results indicated that the majority of QAS participants were 'likely to be well'. The relatively high mean scores and limited variability in the resilience, belongingness and Priority One satisfaction distributions indicated that the majority of QAS employees were able to *bounce back* from stress, felt a sense of belongingness within the organisation, and were satisfied with the EAP services.

A series of independent sample t-tests were then run to determine if participant's distress and resilience levels differed significantly on demographic and work context factors including gender, whether they had accessed Priority One services or not, whether they were a Peer Support Officer or not, whether they had experienced more than one traumatic event and whether the traumatic event they had experienced was personal or work related. Results presented in Table 5 indicate that significant differences on distress levels existed between participants who had accessed Priority One or not and between participants who were Peer Support Officers or not. Predictably, those people who were most distressed were the people who had accessed Priority One services indicating the services were being used by those who needed them. Peer Support Officers had significantly lower levels of distress than staff who did not occupy this role.

Independent samples t-tests were also conducted to determine participant differences in resilience levels based on the same demographic and work context factors examined above. Significant differences existed between groups who had accessed Priority One services and those who had not. Participants who had experienced trauma and had accessed Priority One had higher levels of resilience than those who had not. The results are presented in Table 6.

Table 5

*Independent Sample t-tests Comparing Participants on Psychological Distress*

| Variable | df | t | p (2-tailed) | Mean Diff | SE | 95% CI | *d* |
|---|---|---|---|---|---|---|---|
| Gender | 726 | 1.1 | .270 | .58 | .53 | [-.45, 1.62] | .09 |
| EAP Access | 636.26 | -3.69 | .000 | -1.79 | .49 | [-2.74, -.84] | .28 |
| PSO | 67.42 | 3.3 | .002 | 2.39 | .73 | [.95, 3.84] | .40 |
| W/P Trauma | 707 | .27 | .707 | .19 | .69 | [-1.19, 1.56] | .03 |
| 1+ Trauma | 725 | 2.1 | .036 | 1.78 | .84 | [.11, 3.43] | .27 |

*Note.* SE = standard error of mean difference; PSO = peer support officer; W/P Trauma = work or personal trauma; 1+Trauma = more than one trauma experience; Equal variances not assumed for variables EAP access and PSO or not.

Table 6

*Independent Sample t-tests Comparing Participants on Resilience*

| Variable | df | t | p (2-tailed) | Mean Diff | SE | 95% CI | *d* |
|---|---|---|---|---|---|---|---|
| Sex | 733 | -.94 | .349 | -.05 | .06 | [-.16, .06] | .07 |
| EAP Access | 725 | 5.06 | .000 | .27 | .05 | [.17, .38] | .39 |
| PSO | 733 | -.96 | .340 | -.09 | .1 | [-.29, 1.02] | .14 |
| W/P Trauma | 713 | -1.28 | .200 | -.09 | .07 | [-.24, .05] | .13 |
| 1+ Trauma | 732 | -.07 | .946 | -.01 | .09 | [-.18, .17] | .01 |

*Note.* SE = standard error of mean difference; PSO = peer support officer; W/P Trauma = work or personal trauma.

*Objective Usage Data*

Objective usage data collected for 2011 showed that on 1,650 separate occasions, a different member of the QAS used the PSO program (more than half of the QAS employees). There were a total of 2,163 contacts that were responded to by 89 PSO's. The 45 external

Professional Counsellors throughout the state provided support for 795 individual officers on 2,368 occasions ($M$ = 2.98) during the 2010 year. In 2011 the external counsellors provided 891 clients with their services on 2,588 occasions ($M$ = 2.90). The usage data identified that there had been significant increases in Priority One usage for Paramedics, Classified Officers, Emergency Medical Dispatchers and Student Paramedics. In 2011 personnel accessed counsellors most often for work related stress, followed by marital/relationship issues, anxiety, personal stress/tension and depression. In the same year personnel sought assistance from Peer Support Officers most often for work related trauma, followed by personal stress/tension, interpersonal difficulties with a supervisor or manager and marital/relationship issues. Interestingly more females than males accessed counsellors when taking into account the proportions of males and females in the QAS. Although females make up approximately 30% of the total staff, 47% of people who accessed counselling were female.

## Discussion

The research outlined in this document used a rigorous and comprehensive design in order to investigate the Queensland Ambulance Service's employee assistance program known as Priority One. A review of current best practice revealed the gold standard in making such assessments to include:

1. A thorough review of scientific literature.
2. An independently coordinated committee of stakeholders to oversee the research.
3. Selection of scales that provide validated self-report measures.
4. Themes extracted from stratified focus group data to further inform survey construction specific to the organisational context, and to provide a means of triangulating data.
5. Usage data of how many personnel access particular services provided and for what reasons specific services are being accessed.
6. Questions regarding satisfaction with the services provided.

All of these methods of investigation were included in the current study.

The first question asked of the data was if QAS personnel who had actually used the Priority One services had different levels of satisfaction with the services when compared to those who had not. With the exception of telephone counselling and supportive debriefing, data indicated that people who had accessed the services (peer support, external counsellors

and internal counsellors) were significantly more satisfied with services than those who had not accessed them, which in itself is a positive endorsement of the program. Overall the results suggest that QAS personnel are satisfied with the services that Priority One provides both in general and in terms of specific services. For example, external counsellors and peer support officers were particularly noted as worthwhile and important components of the program and attracted high levels of endorsement from all participants.

In addition to assessing satisfaction with the EAP, a number of scales assessing various aspects of well-being were used. This approach to the research was designed to provide measures of well-being that essentially were used to ask the "So what?" question: "*So what* if personnel are satisfied with Priority One services; what does that mean for well-being?" Correlations conducted between these scales and the staff support satisfaction measure demonstrated that staff who were accessing services and were satisfied with those services were significantly more satisfied with the giving nature of their work role (i.e., compassion satisfaction), perceived a greater sense of connection and belongingness with the organisation, and were less likely to suffer from burnout. Staff who were satisfied with the EAP were also more likely to feel that the QAS valued and respected them as employees; that they belong and are an integral part of the organisation.

The well-being data collected demonstrated that overall, the QAS staff are psychologically healthy with low levels of burnout and secondary traumatic stress and comparatively high levels of compassion satisfaction. Results also demonstrated low levels of distress and moderately high levels of resilience, workplace belongingness and satisfaction with the services Priority One provides. This is a positive picture for the general well-being of QAS personnel bearing in mind that cross-sectional research can only demonstrate the direction (positive or negative) and strength of relationship between variables, and cannot establish causality.

Staff who had accessed Priority One services had higher levels of distress than those who had not, which is to be expected; if a participant did not experience distress there would be little point in accessing staff support services. An encouraging result in terms of the efficacy of services provided is that those who had accessed services were also significantly more resilient than those who had not. Further, those personnel who occupied a peer support officer role had higher levels of resilience and other indices of well-being than those who did not occupy such a role. It may be that this result is due to the self-selected nature of a peer

supporter but may also be as a result of the training they undergo prior to taking on such a role. For example, part of the PSO training is about reflection of one's own internal states and psychological well-being. Psycho-education may serve to protect against negative psychological consequences and promote mental health. In addition to this is their access to ongoing supervision and sense of being part of a cohesive network of other peer support officers. This finding has implications for all members of the service and highlights the advantage of keeping psycho-education an ongoing priority for all staff.

A major strength of this research is in the comprehensiveness of data collected. When taken together, the usage data, focus group themes and survey results can be triangulated to provide an overview of the efficacy of the Priority One program. Triangulated data suggests high levels of satisfaction with the employee assistance program in general, with particularly high endorsement of the peer supporter and professional counsellor components. Furthermore, stress, whether perceived to originate from *management* or the *organisation* more broadly can be reduced through accessing the program, resilience can be enhanced, compassion satisfaction heightened and burnout reduced. Triangulation also sheds some light on the differences between males and females who participated in this research. Females were less likely to experience burnout or traumatic stress than males and were also more satisfied with all Priority One services with the exception of external counsellors with whom males and females were equally satisfied. Combining these survey results with the usage data, it can be seen that proportionately more females than males are accessing services. This trend is consistent with previous research that suggests males are more likely than females to wait until an issue has become a significant problem before seeking assistance (Mansfield, Addis, & Mahalik, 2007).

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